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An Evaluative Study on The Impact of Reiki Therapy in Easing Dysmenorrhoea Among Adolescent Girls Studying in Selected Institutions Belagavi, Karnataka.

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ABSTRACT:
Dysmenorrhoea is a prevalent condition among adolescent girls, often leading to physical discomfort, psychological distress, and reduced academic performance. While pharmacological treatments are effective, their side effects have led to increasing interest in complementary therapies such as Reiki. **Objectives:** To assess the baseline severity and prevalence of moderate dysmenorrhoea and to evaluate the effectiveness of Reiki therapy in reducing pain intensity among adolescent girls. **Methods:** A quantitative quasi-experimental pre-test and post-test control group design was used. A total of 90 adolescent girls with moderate dysmenorrhoea were selected through purposive sampling and divided into experimental (n = 45) and control (n = 45) groups. The experimental group received 30 minutes of structured Reiki therapy along with daily self-practice over three menstrual cycles, while the control group received routine care. Data were collected using a socio-demographic questionnaire and the WaLIDD Scale. Statistical analysis included the Wilcoxon signed-rank test and Mann–Whitney U test. **Results:** The experimental group showed a significant reduction in median pain scores from 9.00 at baseline to 5.00 by the fourth cycle ($p < 0.05$). In contrast, the control group showed no significant improvement, with median scores remaining at 10.00. Between-group comparisons revealed statistically significant differences from the second cycle onwards. **Conclusion:** Reiki therapy is an effective, safe, and non-pharmacological intervention for reducing dysmenorrhoea and improving overall well-being among adolescent girls.

INTRODUCTION:

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1. OVERVIEW:

For many girls, menstruation marks a time to celebrate the transition from girlhood to womanhood; however, a large number of girls experience dysmenorrhoea, which is the medical term for painful menstrual cramps.[1] Dysmenorrhea is one of the most common gynaecological conditions affecting adolescent girls of reproductive age, particularly adolescents and young adults. It is characterized by cramping pain in the lower abdomen that typically occurs just before or during menstruation.[2]

Dysmenorrhea is categorized into two types: primary and secondary dysmenorrhea. Primary dysmenorrhea (PD) is described as painful menstrual cycle or cramps felt in the lower abdomen before and/or during menstrual cycle without a clinically defined organic pathology. And Secondary dysmenorrhea (SD), on the other hand, refers to menstrual pain caused by anatomical and/or significant pelvic pathology such as endometriosis. The onset of PD usually occurs during puberty (< 20), approximately 6–24 months after menarche, and is characterized by painful cramps lasting 8–72 h, which are most severe on the first or second day of menstrual cycle.[3] PD is caused by the hypersecretion of prostaglandins with increased uterine contractility that restricts blood flow, leading to pain. PD may be associated with central sensitization symptoms and has significant impact on quality of life, such as limited daily activities and psychological stress[4]. Menstrual pain significantly interferes with the daily functioning and psychological well-being of adolescent girls. Among adolescents, particularly those in professional health courses dysmenorrhea may contribute to poor academic performance, absenteeism, lack of concentration, and emotional distress.[2] Other symptoms are nausea, vomiting, loss of appetite, backaches, leg aches, weakness, diarrhoea, headaches, sleeplessness, urinary frequency, facial blemishes, flushing, general aching, depression, irritability, nervousness, fatigue or dizziness[1]

It is recognized that PD affects adolescent girls and women worldwide, with prevalence estimates ranging between 16 and 91%. In Brazil, the prevalence of PD among women exhibits variability, indicating rates of 90.7% during the most recent menstrual cycle, 91.4% in the three previous cycles and 97.4% in the last 5 years, covering symptoms that range from mild to severe. Untreated PD may result in absenteeism from school and work, with significant socioeconomic consequences. In this context, pharmacological interventions (prescribed or cases, non-steroidal anti-inflammatory drugs (NSAID) are used as first-line treatment for PD, and the use of combined oral contraceptives also is a treatment option for many women who are seeking contraception. However, those medications can have side effects such as irregular bleeding, headaches, nausea, epigastric pain, oedema, rash, the sensation of heaviness, drowsiness and increased risk for cardiovascular events, ulcers and thrombosis[4]

Menstrual pain significantly interferes with the daily functioning and psychological well-being of adolescent girls. Among adolescents, particularly those in professional health courses dysmenorrhea may contribute to poor academic performance, absenteeism, lack of concentration, and emotional distress[2]. Studies have shown that many adolescent girls endure menstrual pain without adequate medical intervention, often due to lack of time, awareness, or concerns about the long-term effects of analgesics[5]. The demanding clinical schedules, combined with academic workload, can amplify the perception of pain, making it essential to find sustainable, non-pharmacologic options for symptom relief.

Pharmacological management of dysmenorrhea primarily includes non-steroidal anti-inflammatory drugs (NSAIDs) and hormonal contraceptives. While effective, these medications are associated with potential side effects such as gastrointestinal irritation, dizziness, or hormonal imbalances [6]. As a result, Healthcare systems can be classified into two main categories: 1) conventional medicine (also referred to as modern, Western, mainstream, or allopathic), and 2) traditional medicine (encompassing indigenous medicine and Complementary and Alternative Medicine). Conventional medicine can be understood as a system that relies on a Western medical concept that prevents, treats and rehabilitates symptoms and diseases through evidence-based practices, including drugs, radiation or surgical procedures. Complementary and Alternative Medicine (CAM) has been defined by the World Health Organization (WHO) [7]. There is increasing interest in complementary and alternative therapies (CAM), which are generally safer, more holistic, and aligned with integrative approaches to health care[6]. One such therapy is Reiki, reiki therapy is a form of energy healing developed in Japan by Mikao Usui, a Japanese energy-healing technique that involves the transfer of universal energy through the hands of the practitioner to the patient to activate the body's energy field can lead to illness or discomfort. Its aim is to correct these imbalances, promoting relaxation, reducing stress, and alleviating pain.
Despite its potential, the use of Reiki for managing dysmenorrhea remains underexplored, especially in targeted populations like adolescent girls, who may benefit from its non-invasive nature and stress-relieving properties.

This study aims to evaluate the impact of Reiki therapy in easing dysmenorrhea among adolescent girls of selected nursing institutions, contributing to the growing evidence base for integrating complementary and alternative therapies (CAM) in menstrual health care, social and emotional well-being [8]

This study aim is to evaluate the effectiveness of Reiki therapy in alleviating the intensity of dysmenorrhea among adolescent girls of selected colleges, thereby exploring its feasibility as a supportive, complementary intervention within academic health settings.[9]

MATERIALS AND METHODS:

This study adopted a quantitative research approach to objectively evaluate the effectiveness of Reiki therapy on moderate dysmenorrhoea among adolescent girls. A quasi-experimental pre-test and post-test control group design was used, with 90 participants (45 experimental and 45 control) selected through purposive sampling. The experimental group received structured Reiki therapy for 30 minutes along with daily self-practice over three menstrual cycles, while the control group received routine care. Data were collected using a socio-demographic questionnaire and the WaLIDD Scale, a validated tool measuring pain severity, duration, location, and impact on daily activities. Inclusion criteria included adolescent girls aged 18–24 with moderate dysmenorrhoea, while those with gynecological disorders or prior Reiki exposure were excluded. Ethical approval and informed consent were obtained prior to data collection. The study was conducted in two phases: a survey phase to identify eligible participants and an evaluation phase to assess intervention effectiveness across four menstrual cycles. Data analysis involved descriptive statistics and inferential tests such as the Wilcoxon signed-rank test, Mann–Whitney U test, and Fisher's exact test to determine the significance of findings.

RESULTS:

Socio-demographic Profileand Baseline Characteristics:

Table 1 presents the distribution of socio-demographic characteristics across experimental and control groups.

Table 1: Distribution of Participantsby Socio-demographic Characteristics

		Group			
		Experimental		Control	
		n	%	n	%
Age	17	2	4.7	0	.0
	18	7	16.3	3	7.5
	19	8	18.6	11	27.5
	20	13	30.2	9	22.5
	21	7	16.3	3	7.5
	22	4	9.3	7	17.5
	23	1	2.3	7	17.5
	24	1	2.3	0	.0
Course of Study	GNM	8	18.6	14	35.0
	B.Sc. Nursing	32	74.4	19	47.5
	Post Basic B.Sc. Nursing	3	7.0	7	17.5
Year of Study	1st Year	14	32.6	18	45.0
	2nd Year	18	41.9	11	27.5
	3rd Year	7	16.3	3	7.5
	4th Year	4	9.3	8	20.0
Religion	Hindu	31	72.1	31	77.5
	Muslim	1	2.3	1	2.5
	Christian	11	25.6	8	20.0
	Other	0	.0	0	.0
Type of Family	Nuclear	31	72.1	39	97.5
	Joint	11	25.6	1	2.5
	Extended	1	2.3	0	.0
Area of Residence	Rural	17	39.5	19	47.5
	Urban	26	60.5	21	52.5
Mother's Education	Illiterate	1	2.3	0	.0
	Primary	13	30.2	3	7.5
	Secondary	16	37.2	23	57.5
	Graduate & above	13	30.2	14	35.0
Age at Menarche	11.00	4	9.3	0	.0
	12.00	5	11.6	2	5.0
	13.00	11	25.6	18	45.0
	14.00	15	34.9	20	50.0

	15.00	6	14.0	0	.0
	16.00	2	4.7	0	.0
Menstrual Cycle regularity	Regular	43	100.0	40	100.0
	Irregular	0	.0	0	.0
Duration of Menstrual Flow	2.00	0	.0	1	2.5
	3.00	1	2.3	4	10.0
	4.00	15	34.9	5	12.5
	5.00	19	44.2	23	57.5
	6.00	5	11.6	3	7.5
	7.00	3	7.0	4	10.0
Interval between Cycle	28-35	1	2.3	17	42.5
	25.00	2	4.7	0	.0
	28.00	31	72.1	19	47.5
	29.00	3	7.0	0	.0
	30.00	1	2.3	0	.0
	31.00	1	2.3	0	.0
	35.00	4	9.3	4	10.0
Flow Quantity	Mild	4	9.3	20	50.0
	Moderate	39	90.7	20	50.0
	Heavy	0	.0	0	.0
Duration of pain during cycle	<1 day	23	53.5	5	12.5
	1-2 days	17	39.5	27	67.5
	>2 days	3	7.0	8	20.0
Family history of dysmenorrhea	Yes	18	41.9	11	27.5
	No	18	41.9	20	50.0
	Not sure	7	16.3	9	22.5
Effectiveness of current method	Effective	10	23.3	2	5.0
	Somewhat Effective	20	46.5	23	57.5
	Not Effective	13	30.2	15	37.5

As depicted in Table 1, participants in the experimental group were predominantly aged 20 years (30.2%), where as the control group most commonly comprised 19-year-old participants (27.5%). The majority enrolled in B.Sc. Nursing programs (74.4%) experimental; 47.5% control). Most participants identified as Hindu (72.1% experimental; 77.5% control) and resided in nuclear family structures (72.1% experimental; 97.5% control). Urban residency was slightly more prevalent in the experimental group (60.5%). These demographic distributions are broadly consistent with those reported in prior studies of dysmenorrhoea among Indian adolescent student populations.

Menstrual Profile of Participants:

Menarche was most commonly attained at 14 years of age (34.9% experimental; 50.0% control). All participants reported regular menstrual cycles. Menstrual flow duration offive days was the most prevalent pattern (44.2% experimental; 57.5% control), and a 28- day cycle interval was reported by 72.1% of experimental group & 47.5% of the control group. Moderate menstrual flow predominated in the experimental group (90.7%), while mild and moderate flow were equally distributed in the control group (50% each).

Pain Distribution and Associated Symptoms:

As summarized in Table 2, the lower abdomen constituted the primary locus of dysmenorrhoea pain, either in isolation (44.2% experimental; 25.0% control) or with concomitant radiation tothe thighs(44.2% experimental; 67.5% control). Pain confined to the thighs alone (2.3% experimental; 0% control) or the lumbosacral region (9.3% experimental; 2.5% control) was comparatively less common.

Table 2: Distribution of participants by Site of pain

		Group			
		Experimental		Control	
		n	%	n	%
Site of pain	Lower abdomen & Thighs	19	44.2	27	67.5
	Lower Abdomen	19	44.2	10	25.0
	Lower Back	4	9.3	1	2.5
	Thighs	1	2.3	0	.0
	Lower abdomen, Lower Back & Thighs	0	.0	1	2.5
	Lower abdomen & Lower Back	0	.0	1	2.5

Table 2 the lower abdomen was the most often reported site of pain, either by itself (44.2% experimental; 25% control) or in conjunction with the thighs (44.2% experimental; 67.5% control). Pain in the thighs alone (2.3% experimental; 0% control) or lower back (9.3% experimental; 2.5% control) was less common. Just 2.5% of individuals reported having pain in more than one place, such as their thighs, lower back, and lower abdomen. This suggests that the lower abdomen is the main location of dysmenorrhea pain, which frequently spreads to the thighs.

Associated Symptoms:

Regarding associated symptomatology, mood swings constituted the most prevalent concomitant symptom in both groups (18.6% experimental; 20.0% control), followed by leg cramps and diverse symptom combinations including nausea, headache, fatigue, and their permutations. The experimental group demonstrated a broader heterogeneous symptom profile, whilst leg cramps combined with mood swings were proportionally more common in the control group. These finding corroborate the multidimensional symptom burden of dysmenorrhoea documented in prior literature, extending beyond somatic pain to encompass significant psychological and functional dimensions

Effectiveness of Reiki Therapy — Within-Group Analysis

Table 3: Within-Group Comparison of WaLIDD Scale Scores — Cycle 1 vs. Cycle 2 (Wilcoxon Signed-Rank Test)

Cycle	Exp.Median	Exp.IQR	Con. Median	Con.IQR	Z/Sig.
Cycle1	9.00	3.00	10.00	2.00	—
Cycle2	9.00	2.00	10.00	2.00	—
ZStatistic	−4.184		−1.72		
p-value	<0.05*		0.864		NS

As presented in Table 4, the Wilcoxon signed-rank test revealed statistically significant reduction in dysmenorrhoea pain within experimental group from Cycle 1 to Cycle 2 ($Z = -4.184$, $p < 0.05$), with reduced score variability (IQR: 3.00 → 2.00) indicating greater therapeutic consistency. In contrast, control group demonstrated no significant change across this interval ($Z = -1.72$, $p = 0.864$), confirming the absence of spontaneous improvement without active intervention.

Table 4: The impact of Reiki therapy in easing moderate dysmenorrhea from cycle 1 to cycle 3 among adolescent girls in selected institutions (within group comparison)

	Experimental		Control	
	Median	IQR	Median	IQR
Cycle 1	9.00	3.00	10.00	2.00
Cycle 3	7.0	2.0	10.0	2.75
Z	-5.552		-2.282	
Sig.	<0.05*		0.778	

*<0.05 significance is obtained by Wilcoxon sign rank test

Table 5 The experimental group's median pain score dropped from 9.00 to 7.00, which was statistically significant ($Z = -5.552$, $p < 0.05$), as shown in Table 5. Nevertheless, the control group's median pain remained at 10.00 ($p = 0.778$), indicating no discernible improvement. This suggests that Reiki therapy gradually lessens the discomfort associated with dysmenorrhea.

Table 5: The impact of Reiki therapy in easing moderate dysmenorrhea from cycle 1 to cycle 4 among adolescent girls in selected institutions (within group comparison)

	Experimental		Control	
	Median	IQR	Median	IQR
Cycle 1	9.00	3.0	10.0	2.0
Cycle 4	5.0	2.0	10.0	2.0
Z	-5.717		-0.678	
Sig.	<0.05*		0.537	

*<0.05 significance is obtained by Wilcoxon sign rank test

Table 6 The experimental group's median pain dropped from 9.00 to 5.00 in Table 6, which was statistically significant ($Z = -5.717$, $p < 0.05$). The control group, on the other hand, did not exhibit any significant decrease (median stayed 10.00; $p = 0.537$). This demonstrates Reiki therapy's ongoing and growing efficacy across menstrual cycles.

Table 6: Comparison of Reiki therapy in easing moderate dysmenorrhea between experimental and control group in all cycles

	Experimental		Control				
	Median	IQR	Median	IQR	U	Z	Sig.
Cycle1	9.00	3.00	10.00	2.00	724.500	-1.257	.209
Cycle2	9.00	2.00	10.00	3.00	529.000	-3.066	.002*
cycle3	7.00	2.00	10.00	2.50	209.000	-6.014	<0.05*
cycle4	5.00	2.00	10.00	2.00	41.000	-7.524	<0.05*

Association:
This demonstrates comparability by showing that there was no significant difference between groups at baseline (Cycle 1) (p = 0.209). But starting in Cycle 2, a statistically significant difference was noted (p = 0.002), and in Cycles 3 and 4, it became extremely significant (p = 0.000). While the control group's median pain scores stayed at 10 throughout cycles, the experimental group's scores consistently decreased. This proves unequivocally that, when compared to no intervention, Reiki therapy greatly reduces dysmenorrhea.

DISCUSSION:
The present study showed a significant decrease in dysmenorrhoeal pain among adolescent girls after receiving Reiki therapy, as indicated by the gradual reduction in median pain scores over consecutive menstrual cycles. This finding is supported by previous research suggesting that Reiki can help relieve pain by promoting relaxation and improving mind–body responses [10]. The lack of change in the control group further confirms the effectiveness of the intervention. Similar results have been reported by Lee et al., who found that complementary therapies are more beneficial than routine care in reducing pain[11]. Overall, the study supports Reiki therapy as an effective non-pharmacological method for managing dysmenorrhoea.

CONCLUSION:
It exists a statistically significant variation between the pre- and post-test pain scores between adolescent girls who received Reiki therapy throughout three menstrual cycles. In the treatment group, median pain levels fell from 9.00 to 5.00, whereas the control group remained at 10.00. In addition, the experimental group experienced less related complaints such as fluctuations in mood, headaches, nausea, and exhaustion. Thus, we can say that Reiki therapy is an efficient and secure non-pharmacological intervention for treating dysmenorrhea and enhancing general comfort in adolescent girls.

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